Peer-Led Care Navigation Affinity Group Session Three

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Isaiah Lopez: Hi, I'm Isaiah Lopez and I want to thank you for joining the third and final session of the CJR Peer-led Care Navigation Affinity Group. Today's webinar will include a review of the Affinity Group progress and opportunity for discussion on overcoming challenges to care navigation with the focus on optimizing patient health prior to surgery. I'll now turn over to Laura Maynard.

Laura Maynard: Thank you, Isaiah. Welcome everyone. We're glad to have you with us today. This is Laura Maynard and I'm here with other members of the CJR Learning System Team, including Lauren Nir. We're going to be helping facilitate today, but our primary facilitation today will come from our peer leaders. We have with us Jody Harclerode from Geisinger Holy Spirit Hospital, Dawn Rakiey from University Medical Center, Randy Thomas from Hackensack University Medical Center and Sheyda Namazie from BJC HealthCare.

What we're hoping to cover today, we're going to do a little bit of logistics, get you oriented to things. We'll revisit our goals for this Affinity Group and then we're going to have some really open discussion to talk about challenges you may be facing in care navigation and how you're overcoming those challenges. Then we'll close out the session with some announcements and reminders.

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This is the opportunity for us to share peer-to-peer for you all to talk to one another and share your strategies, your approaches, and your tactics, and learn from each other. In a little bit we're going to unmute all the phone lines. Right now they're muted, but soon we will unmute all the lines. We'll tell you when we're doing that. At that time you'll probably want to mute your own local phone line, if you have any background noise. We want to encourage you to speak up, to share, to ask questions, to talk to one another, to have conversations. That's easier if you dial in over a telephone. So, if you're listening over your computer speakers and you're thinking that you might want to have a conversation with us, please dial-in to the telephone using the dial-in information that's in the upper right-hand corner of your screen.

Just under that dial-in information is your chat pod. We'll be using that here very soon. There's also beside that, just to the left of that event resources and that's where you can download the bios of our peer leaders, the slides for today, the charter and commitment statement, many different resources are there. To download those, you just click on them, each one, click one, download it, click the next one, download it, and you're able to get them all in that way. Just to the left of that is closed captioning if that's needed. Above the slide is a little raise your hand icon, so at different points during this session, we may ask you to raise your hands to sort of take an informal poll, and in order to do that, you just look straight up above the slide. You see the little symbol of someone waving or raising their hand. When you click on that, you'll raise your hand. When you click it again, it lowers your hand.

Let's start out using that chat pod. We would like for you to introduce yourselves there and please share in chat your organization and a challenge that you're facing in care navigation. What's one challenge that you're working with? Something that you're struggling with currently or that you've recently struggled with and have some approaches working to overcome that, but type into that pod your organization's name and then a challenge that you're facing in care navigation. As you're doing that, I'm going to talk a little bit to remind us of the goals of this group. This is the last formal session and the last virtual session of this Affinity Group, this Peer-led Care Navigation group. What we were hoping to accomplish through this is to share care navigation and care coordination tools and resources, to discuss strategies, challenges, and lessons learned and to learn from each other. So, I'd be thinking about how well have we done that so far? How's that going? Have we shared tools and resources? Have we shared strategies, challenges, and lessons, and are we learning from one another?

Also think about that charter and commitment statement for this group. The primary commitments that we made to each other in this group were to participate, that you would speak up, that you would upload resources, that you would share things with each other. We want that type of sharing and learning to continue even after the group is not meeting in these virtual sessions anymore. You'll still be able to talk to one another on Connect. You'll still be able to reach out and participate in group learning. So we're going to start next by a poll to see what are you going to commit to doing after this session to keep the conversation going and to keep this networking that we've got alive? You can select all that apply. Just click in the box that's to the left and what, what are you going to agree to do, to kind of keep this Affinity Group going?

Will you speak up verbally during today's session we're really hoping that you will. Are you willing to share a tool or a resource that you use at your hospital and share that with another CJR peer? Are you willing to log on to CJR Connect and maybe to post or comment on Connect? We know that a lot of you log on, but few of you actually make a post or a comment and we would love to have more active conversation there. Or are you thinking you might communicate with a CJR peer by e-mail or something else? Is there another way that you're going to try to keep your connections with this Care Navigation, Affinity Group alive and kicking? We'll give you just a few minutes here to click and then we'll show the results, and I'm happy to see that the vast majority of those that responded to the poll are willing to log on to CJR Connect. That's a great place to download resources. It's a great place to share with one another, to share resources, to have conversations, to share ideas. It's really a good place to interact and connect.

So, thanks for that. We'll head back to the slides and at this point I'm going to turn it over to our peer leader, Randy Thomas, who's going to talk us through some conversation.

Randy Thomas: Thanks Laura. Hi everybody. You know, being a peer leader means that I'm just one of you. I'm just trying to do the best for our program and overcome obstacles here. I'm really glad to see, the chat of introductions and I'm seeing some common threads here as well. The phone lines are going to be un-muted. Certainly if you are not speaking, you may want to mute your personal line, but the idea of this is to really just network. Let's talk out loud and help each other through some of the obstacles that we see. I'm just going to start putting it out there and let's see who can speak up. If you're unable to actually speak up because of the location that you're on, please feel free to just write it into the chat room, or if you're uncomfortable doing that then we'll, we'll speak to it as well, but I do ask everybody to, kind of, we can really kind of get down into it and get us as meaty as possible and to, trying to brainstorm some of the ideas. You'll see in the top, in the left-hand part of your screen right now, there is a, a white discussion box, and as we start talking, there's going to be live notetaking there.

So, you know, read on, we don't have slides like we usually do because this is a more informal, open discussion type of presentation, but you will be able to follow along with the discussion there.

Again, putting it out to you and please feel free to speak up. What's the challenge you're facing in care and navigation and how are you working to overcome it? And, if you are having trouble overcoming it, please speak up with your answer or your question as well.

Anyone can speak up when they want to, but one of the things that I saw just from the introductions is that there were quite a number of questions having to do with length of stay, post-acute and I'm asking if the people that brought that up might want to speak forward. There was some fracture length of stay question, but there I think that there was also a general questions about the length of stay at subacute and how to handle that. Does anyone want to speak up and put that out there? Or, if anyone has a way that they're managing around, their length of stays at sub-acutes. If you could speak forward on that as well?

Ellen Jordan, I see that you have posed a question now, are you comfortable with speaking up and maybe saying how you handle some of those things? You're calling in now I see. Okay. Shibani how about you?

Shibani Gupta: Hey Randy, its Shibani. So, for length of stay in subacute, it really is a process that we start when the patient is still in the hospital and sometimes even at the pre op class, at the joint class. Certainly, we try our very best to reinforce with the patient what the length of stay in post-acute is going to be. If they are going to post-acute, we really do try to send them home. One of the challenges definitely is when a patient, despite our education does choose a facility that may not be a CMS three star rated facility or a four or five star, and it's in a different area where we necessarily don't have a lot of partnerships. That definitely does come as a challenge.

Randy Thomas: Yeah, and how do you handle that challenge? If there's patient choice and they go to a facility that's not a three star or higher.

Shibani Gupta: I know. That definitely, that's certainly an area that we are trying to address. I mean, it has to be through patient education and Family Ed, you know, we're really trying to reinforce the importance of going to the facilities, and what their star ratings mean, but it is definitely a challenge that we haven't really been able to overcome just yet. I have found recently that, some patients that come in saying, well, my primary care physician told me I should go to an acute care rehab for my knee replacement. With those patients a lot of education and while they're even in the hospital and telling them why they don't need to go to acute rehab and why, a couple of days in rehab, or even going home with home care that's been successful, but patients choosing to go to facilities, because their family lives close by or whatever the case might be, that one does continue to be a little bit of a challenge.

Randy Thomas: Thanks Shibani. I see Chastity wrote in that you are developing a network and partnership with SNF. Can you fill us in more on that and how that's beginning to take shape? Chastity is typing. I'm not sure if she's able to speak to that.

Ellen Jordan: This is Ellen Jordan, I'm here now.

Randy Thomas: Oh, hi Ellen.

Ellen Jordan: Hi, how are you?

Randy Thomas: Good.

Ellen Jordan: Yes, we're having similar issues but mostly with our fracture patients and the length of stay that they are in rehab and the expectation of the facility, the expectation of the family is stay for 88 days if needed. When we really believe that patient can recognize that they're going to never be able to live alone, they were in a very gray area before they fell, and let's start planning that two weeks in or a week in, is a hard nut to crack even in our partnership rehabs. I'd like to say for our joint patient it is excellent. I'd say most are seven days. We've come down from the last five years, typical length of stay of 30, 20, 18, and now we're down to around 7 to 9 days in our partnership rehab.

Randy Thomas: Is everybody finding there an answer kind of coming back on what you just said Ellen. If you have partnership with the rehabs or are you all finding that that is so much more instrumental? Has anybody been making headway with SNFs that are not partnered with your hospital? I say that just from the standpoint I'm guessing there are some people like where I am in northern New Jersey where there are so many SNFs and our patients coming from around and we have a few that we're in partnership with. We have a lot that were not and so we are still trying to get a collaboration and playing in the sandbox that people that are not a partner with us. Has anybody else been able to accomplish any headway in that way?

Sheyda Namazie-Kummer: Randy, this is Sheyda from BJC HealthCare and we're struggling a lot with that right now as well. In our catchment areas we had collaboration agreements with about 40 SNFs via our ACO and honestly we found that we were only sort of engaging about 30% of our patients because we have so many SNFs in the area. It's really sort of been a process of going out to every small one-on-one and trying to educate and sort of speak to the leaders there. But we hit a lot of resistance, particularly with some of our more rural area SNF. I'm really interested in understanding how others have approached that besides the one-on-one which is definitely time consuming and difficult.

Randy Thomas: I would agree with that. It is time consuming and yet I think there could be small strides that are made with just consistent communication there. Does anybody ---

Ellen Jordan: This is Ellen again. I would agree it is time consuming, but I think it's valuable to put a face to our facility. They know how I work. I offer to assist them and send a report of how the patient was that's not in a physical therapy report or that's not generally in the nursing report. Let me tell you what their home situation is like sort of in the background, but it's not part of the chart anywhere. I think a little give and take and we have a written protocol and I sort of in a gray, vague way, if they're not going to follow our protocols, we're not going to be able to send them there. However, I'm very kind of enthusiastic about sending our patients to their wonderful facility if they are five star, I kind of use that. We really want them to be able to come here and even if they're not in our partnership it has been working okay.

Randy Thomas: I think that I've seen the same thing as you have seen. If you approach the facilities that are not partnered with you and in a way that's very conversational and supportive, they are more apt to see your patients if that's the best location for the patient post-op, because you know that they are working together with you, even if it's not a partnership. Even knowing that they still don't want to lose

your business, they want to gain some business. That's one way to do it. Shibani I see that you had your hand raised. Was that relative to this or a new topic?

Shibani Gupta: A little bit, I mean, I think one of the things I was thinking about, and it's probably not applicable to all areas, but maybe in some cluster areas like northern New Jersey where you and I are, Randy, I think it may be beneficial for us to share our SNF resources a little bit. That way if a patient does go to a non-preferred providers SNF for us but they happen to be a SNF you're working with, if the SNFs know about the hospitals communicate on their performance, I think there's like a tertiary benefit to them of knowing that they have to perform the same for all hospitals and all providers. I now recognize that may not apply to areas where there's not as many hospitals in the area, but that's just something that I've been thinking about.

Randy Thomas: Yeah. Speaking about SNFs and there's what we spoke about a few minutes ago, there is the element of the joint replacement patients and I think most people have seen their SNF length of stay come down in that arena, but certainly there was the issue brought up with our hip fracture patients and that was an extraordinary length of stay that you were talking about that, who was that Ellen or was that?

Ellen Jordan: Yes.

Randy Thomas: Yes, talking about before. Has anyone else been able to, if you could either speak up or type in, has anyone else been able to decrease length of stay or work with SNF or create a same type of program level of care to move the patients along with the hip fracture patients, because I don't know anyone that's not a bit challenged by that patient population. Okay. No one has cracked that nut I'm guessing.

Ellen Jordan: Yeah, I agree that is a tough nut and within the fracture population, you've got a different population. You've got your dementia patients. In that one, those folks are, bless our hearts, so there's not a whole lot you can do. But I think with the ones that do improve with some rehabilitation, you can still put the expectation on the facilities of a length of stay within your protocol. But again the dementia patients are just, those are the, there's really not much you can do with them. They're very, very difficult so we kind of look at them in two different ways that those that can progress with rehab and those that just won't because of their dementia, which is---

Randy Thomas: Right, their preoperative status or their pre-trauma status certainly lends a lot into that and also there social situation somehow have managed to live by themselves and then they just can't any longer and that presents a whole separate challenge there. I think the whole SNF conundrum or the reality that not everybody can go home I think that continues to be a work in progress for anybody. I applaud everybody that's working with and I think hospitals or systems are moving to partner with more and more SNFs so that they can really have a better hand and as well as perhaps education to the SNFs to get more desirable outcomes. There's another, if I could switch topic areas for a moment. There was another topic that came up and it's up further in the scroll of the chat. Somebody had brought up optimizing prior to elective surgery. Can the person that brought that up speak up or type back in? Let's see if I could find that.

Ellen Jordan: That was Chastity.

Randy Thomas: Oh, it's Chastity. I give you so much credit Chastity because you are typing up a storm here in your response since you can't speak to us. Thank you for that. There we go. Smiles back to you. What are people doing as far as optimizing prior, are there people that have optimization clinics as part of their joint preparation in their hospital where patients go to one location?

Wilson Phoeng: Hi, this is Wilson. I'm an orthopedic nurse navigator at UCLA Santa Monica Medical Center and we have a mandatory preoperative class in terms of assisting with optimization of and setting expectations prior to coming in for surgery. We also have an anesthesiologist-led clinic called the PEPC clinic: preoperative evaluation and planning center where we can send all our patients that are not optimized to the clinic to optimize but just BMI greater than 40, high hemoglobin, A1c, cardiac risk, pulmonary risk, anything anemia, any kind of risk barriers that we think should be optimized specifically we can refer them to and they'll get optimized and then once they're fully optimized then they get scheduled for surgery. So it's been a great resource and it's been a great tool to make sure that our patients have help before coming in for surgery.

Randy Thomas: Yeah, thanks for that feedback, Wilson. I was just about to call on you anyway because I see you volunteered some information. I was getting a little clicking from your phone, but I thank you for that. A question to you, was the optimization clinic, was that created specifically for the joint patients or did that already exist in the hospital and your joint patients just go there as well?

Wilson Phoeng: Yes, that's actually a service for the entire hospital, the entire UCLA System. So for both Ronald Reagan Medical Center as well as Santa Monica and the fact that they were lacking in terms of referrals, they reached out to the joints program because we had a high case volume we actually pilot that to make sure that all our patients there because they have a huge office a huge clinic and they can serve a lot of patients. They were lacking in terms of referrals from all other services within the hospital system, so I think we're probably the number one users in terms of referrals to that clinic specific optimization.

Randy Thomas: Thank you very much for that information. Has anyone developed an optimization clinic specifically for their joint patients where your hospital didn't have an overarching optimization clinic? I know that that has come to us as a suggestion from Joint Commission for our program, we would love it. It's quite an undertaking and I just didn't know if anybody else had embarked on that.

Jody Harclerode: This is Jody. I can tell you what we did because of the undertaking we just utilized our weight management. We have a bariatric program and when I met with them everything that they do is similar to what you need to do with optimizing your elective joints. We refer our patients there. They even do the A1c assistance with that as needed, but the majority of our optimization needs are related to BMI and it doesn't mean, I tell the patients it doesn't mean you need bariatric surgery. That's what we do. I would be curious from the group if there's anyone who has an optimization program, if it's just an optimization clinic, do you charge for that visit or not? That's a question I've had that popped into my head today.

Wilson Phoeng: I believe our program at UCLA, it's currently not billable. So it is a free service for referrals. I think as of right now they are unable to bill for their optimization.

Chastity King: Hey guys, this is Chastity. I was able to dial in. Sorry about all that typing.

Randy Thomas: You would just want to give your fingers a rest there, right?

Chastity King: Yeah, I'll go to my voice.

Randy Thomas: Well, thank you for finding a place and dialing in and I know you may want to give some feedback to what we're discussing, but at the same time I see and I was going to mention is that you have, I'll read your sentence here. You have an extensive risk assessment tool that you use prior to surgery and we are not participating in Strong for Surgery protocol from the American College of Surgeons, so there's certainly some interest regarding that. Now we get to hear you voice to voice.

Chastity King: Yes. On the part with our risk assessment tool, so we're just kind of putting in a new one. We had one, I tweaked it a little bit when I came on board here. It's very extensive. It's a good two pages. Our goal is to have this built into Epic, which is our electronic medical record. So that way it's easier on the nurses who are performing this and it will actually go to, let's say we put in a BMI 36.5. Well, that's going to automatically send a referral to a dietary. Let's say that we put in that the patient smokes. So our goal is that that automatically puts in a consult to our population health nurses. We have a lot of big dreams. We're working on it, but we do believe that it does start with that risk assessment tool.

Randy Thomas: Did you create that tool yourself?

Chastity King: Yes, ma'am, I did, based on a lot of research and different things from the American Academy of Orthopedic Surgeons and then also the American College of Surgeons. Now we are using the Strong for Surgery protocol, which is a very, very neat protocol that we have initiated. It's on their website if anybody's interested, but it optimizes nutrition, smoking cessation, BMI and medication.

Randy Thomas: How does that tool, the risk assessment tool get completed? Is this done through, I might've missed that, and if, so, I apologize, is this done through a preoperative education? Is this done as part of when they an outreach when they have scheduled for surgery? Is this done by the office even before their schedule so that they can be optimized before they're put on the OR schedule?

Chastity King: Right. Again, we're kind of going through some changes and actually we meet tomorrow with our leadership team to discuss some new changes that I'd like to see take place, but as of right now it is done in the clinic. During that initial consultation where the patient decides to have a joint replacement, then ideally if this goes through the nurse will do the assessment on the computer. Now, right now they do it on paper and then it's scanned into the electronic medical record. Now based off that assessment, it should prompt the nurse in the clinic to then send out the referrals to then send out, for lab work, that sort of thing clearance from PCP, cardiac, that sort of thing. So, that trigger is what we're hoping is the key to optimizing the patients is to getting them cleared, getting their labs drawn, getting them, maybe losing some weight. Then if need to, if need be, we'll have to put the surgery off for four to six months just to get them optimized. Then I think that that's definitely worth it.

Randy Thomas: You mentioned clinic is your clinic just a full faculty practice? Do you have any private physicians?

Chastity King: Nope. Our clinic is our doctor's work for the hospital, so all CHI. I have a little bit of a different role. I actually work for a CIN which is a Clinically Integrated Network. We are population

health nurses. Even though I work under Arkansas Health Network, which is again the CIN for the State of Arkansas, I'm still the orthopedic nurse navigator. But yes, so the clinic is just right off campus here from the main hospital, each physician has a nurse and the nurses are the ones who are doing the risk assessment tools.

Randy Thomas: Then the patients are actually not -- I would guess that you see less cancellation because your patients aren't scheduled until they're optimized or determine the intent --

Chastity King: Yes. The intent -- yes, that's again this is all, this is a great conversation. I'm glad we're having it because, like I said, tomorrow we'll be having these discussions further, but so yes, that's going to be the intent and also to just for the better overall health of the patient so that way they can have better outcomes after surgery.

Randy Thomas: Is there anybody out there, that's hearing this from Chastity and saying, I can make this happen in my facility even having private physicians, not full faculty or not a clinic for it. I'm taking it that people think this is a great idea, but just trying to think of how to operationalize that if you don't have a clinic setting might be difficult.

Dawn Rakiey: Hey Randy. It's Dawn.

Randy Thomas: Yeah.

Dawn Rakiey: We are a teaching hospital where our physicians are employed by our university. What we would love to have months and months to optimize our patients. I think that is awesome. What Chastity is able to do, but we don't really have that if patients aren't it's hard to say. Like we are the county hospital, so I'm not lying when I say we kind of get probably the worst patients to do electives. The boutique hospitals, they can kind of pick the cream of the crop patients. For us patients would not be okay if we're like, hey, we need to, you know, really optimize your care your BMI is out of control, your A1c is out of control. We're looking at four or five months until you have your joint replacement. In a perfect world, I would love that, but that just unfortunately doesn't work in our area. I try to capture them in class, that pre-op class that I teach and just try to give them all the education that I can about, don't smoke, let's get your A1c under control. For the most part like the last six months -- like I always call the people out who smoke in class and so either people are lying or we actually haven't had that many people be current smokers because the physicians are like, Hey, you need to stop. I just wanted to kind of just chime in that we don't have the same ability as Chastity does with patient optimization. I'm actually frankly really jealous of it.

Chastity King: Well, let me, I will say this, let me clarify. This is a -- this has not been easy we live in a very rural area with a high, high population of elderly patients like the majority of our patients are like over 80. They are very, very, we live in Arkansas and so they're very, very, sometimes unhealthy, overweight. It's been a challenge to kind of get our physicians out of the mindset of case, case, case, case, I got to do this many cases that I can and kind of go into the value-based process of healthcare, which is what luckily I work under a CIN, which is, that's all that we're about is value based. It's definitely been a challenge. There's those patients sometimes that we just have to say, we got to do this for the patient because they may not have, a great access to a primary care whatever. But most of our referrals come through primary care physicians so then we're able to get that clearance from them for sure, and then if they have like a cardiac cardiologist or whatever, then we can proceed with that clearance as well. It

doesn't always work out. Right now it's kind of in a battle phase. This is just my rainbows and unicorns thinking.

Randy Thomas: Well, you know, if you don't have rainbows and unicorns, then you can't get as far as many of us have gotten you have to shoot for that. It we won't say stars, we'll say rainbows and unicorns.

Chastity King: Yeah.

Randy Thomas: Has anybody found that some of those surgeons don't like hard stops on some of the modifiable risk factors and they're scared that if they turn a patient down that they'll lose that patient does anyone find that because that certainly ties really right into this optimization piece?

Sheyda Namazie-Kummer: This is Sheyda; Randy. I think that we found some of that here in St. Louis or in Missouri and Illinois. It's really been as Chastity pointed out, a lot of mindset change for our physician. There was a lot of concern initially and we still aren't at a place where perhaps we observe hard stops all the time. I think just having a conversation and getting the physicians to understand the value of the pre-optimization needs and starting that conversation with their patients has been a really good thing because it certainly moved the needle in the right direction even if they're not observing a hemoglobin A1c hard stop all the time or a BMI all the time. I think that we've made progress. It's sort of balancing, the agreed upon cutoffs with the holistic view of the patient. Why might we need to operate sooner rather than later?

Randy Thomas: Yeah, I think so the conversation if lack of anything else that brings it to everybody's awareness and patients are benefiting from that. I want to just ask one question to people and see if anybody will as we are talking and really wrapping up this series here with the Care Affinity Group, has anybody found over the course of the past year with everything going on that they're having difficulty at all prioritizing their roles as care navigators through their programs because it seems it gets quite widespread. Is anyone having trouble prioritizing what to do to get to the end result? I'm sure everyone's role has changed quite a bit over the past couple of years. Okay so not a problem for anybody?

Wilson Phoeng: This is Wilson. It's definitely a problem because, I mean, we are as a ortho-navigator at UCLA I'm part of the clinical side, triage side, I'm part of the pre-optimization pre-operatively with patients in the hospital, I follow them 90 days after, I partner with skilled nursing facilities, our post-acute care providers. I keep track of all the data. It's just a wide range for the single title and to be the only person monitoring all of it. It has changed a lot. It has grown, the volume has grown too. It has been very challenging. Now I'm being pushed to the side where I'm trying to figure out whether or not our elective total knee replacement patients, inpatient procedure, outpatient procedure, I guess a little more complex with this role. Definitely it's going to work and see where all the changes I would love to hear if anyone has any suggestions or if they can tell us in terms of being able to classify our elective needs, knee replacement procedure patients after Medicare has been moved to the inpatient only list that kind of has done a lot of chaos in terms of how we care for those patients here, what resources we have, when we discharge them from the hospital based upon their classification of inpatient or outpatient.

Randy Thomas: Thanks Wilson. Anybody give any input for that? Because that's something that's real time for all of us. I know from our standpoint, Wilson that is something we are still in discussion over. We keep going back and forth, I don't have a clear-cut answer because we sit there and talk about both ends of it on how to basically book the patient, whether it be as an outpatient or as an inpatient and then convert them for whatever fits so that we can handle that correctly. Does anybody --

Wilson Phoeng: I'm glad to hear you are working on that matter as well. Good to hear that.

Randy Thomas: Yeah. Yeah. Well, thanks for that. I think that more to come on that for sure because we're all working towards that, so I really appreciate in this half hour or so we've discussed really how to look to work with SNFs, both SNFs that are part, of connected to the hospitals and the partnership as well as some that aren't and the importance really of opening that conversation whether they are or are not. So our patients can proceed down their road to recovery no matter where they are and as well as their time in the SNF be optimized to get them home safely and as quicker time as possible. We've also spoken about optimization for the patient. A lot of really good things certainly if you have the gift of your hospital having an optimization clinic, that is, almost too good to be true, but also creating your own tool like Chastity did and starting to operationalize that so that you can get on the forefront of really taking care of some needs for your patients to optimize them before they're scheduled for surgery and therefore make a more efficient, OR schedule there, and then really adjusting to the constant changing needs. We have a very fluid program with our joint programs and our role as care navigators are also very fluid and really kind of getting a handle of on that as it morphs some be able to prioritize it the best we can. I thank you for all of that input. It's certainly something that will be ongoing, but we really appreciate you taking part both in through the chat room and verbally as well. I'm going to turn it back over to Laura now.

Laura Maynard: Great. Thank you, Randy. We are going to have a little more opportunity to share on a couple of other topics, but we did want to mention another resource and another possibility in looking at care transitions. We're going to go back to our slides and we're going to look at a poster that came from the National Care Transitions Awareness Conference. This poster is difficult to read as a slide, but if you want to get a better look at it, if you hover above it, there are four little outward facing arrows that'll take the slide full screen. So, if you really want to see it, you can make it full screen and it'll be easier to see. Yes, we got that. We can talk about it. It's also available for download, so we're going to have it available for you on CJR Connect and this has a lot of issues that were raised in regard to the kinds of things that folks face in transitions of care that you all as care navigators are really going to be addressing.

We want to highlight a couple of those and see if you want to maybe share with us a little bit about that. The first is this challenge that they call, surely you have someone, and this is that belief that everybody's got some support system out there in their home and their community. Everybody's got someone. Frankly, not everybody does and you all know that. I was wondering if anybody would be willing to share a few ideas on care navigation for patients that don't have those family or community support. How do you handle that?

Wilson Phoeng: This is Wilson.

Laura Maynard: Please share.

Wilson Phoeng: This is one of our biggest area of concerns of getting patients home, of course, the patients that do have no social support or proceeds themselves as having no social support, they always tend to gravitate towards skilled nursing facility or going home unsafely. We do hit this topic very hard in our preoperative planning class and trying to recruit anyone it can be friends, neighbors, family members, cousins, and we also provide resources for private caregivers that if you want to hire as part of the caregiver or they in advance call the company to see if they do provide coverage for private caregivers, which rarely do they ever, but some may or may not. So just having that discussion upfront in terms of saying that you will need someone to assist you once two weeks after or elective joint replacement and we really require this in order for you to have a successful surgery. Due to insurance constraints, we cannot necessarily get you into a skilled nursing facility without medical clinical needs that allow us to get you into a skilled nursing. Really having that discussion that saying we cannot send you to the nursing facility due to social needs, it can only be based on medical justification and really having that we sit down and continue both follow up. If you have any other questions or concerns, really happy to kind of gravitate the patients towards really figuring out their social support before surgery.

Laura Maynard: Thank you. That's a great approach to begin thinking about it during joint class. Setting that expectation that you will need someone to be there and help you and then help them recruit someone, whether it's someone in the community, whether it's someone that that is hired and helping folks work with that and help train those people, multiple different ways to help those connect that don't have someone to be the caregiver at home. Anyone else approaching that in a different way? Anyone else have other strategies or resources that you use in working with patients that don't really have a support system at home?

Chastity King: This is Chastity. I second, we pretty much have the same approach, Wilson as far as enjoying class and educating. There are those very few that just really like, we can't just say no because they got to have the surgery. We will -- and sometimes front load a home health visit, just to kind make sure that the patient is okay. Of course we have -- we're CHI so we have the CHI home health. We will front load them sometimes with a home health visit. That's very, that does not happen often. Usually like you said, we find someone in the community, maybe a church member even, and a lot of the times if you do some digging, you can find someone that's willing to help the patient even if it is just some days of paying for a private caregiver.

Laura Maynard: Yeah, yeah, excellent. Thank you. Thanks for sharing that. The other one item that I wanted to highlight from that poster, we've already mentioned this briefly, but I thought we'd come back to it just to see if others have something to share on the myth that one size fits all. This is basically the approach that not every patient is the same and not every patient has the same needs, and even if your patient population has a certain amount of similarity to it, sometimes there are going to be patients with unique needs. How do you address that in your care navigation? For example, how do you provide effective care navigation for patients that may have English as a second language or that may have developmental disabilities or that may have a mental health diagnoses? How do you all approach that to really give patient centric care that's individualized to that patient who may have complex or multiple needs?

Chastity King: This is Chastity again. I can kind give you an idea of what we do. As far as like the second language, before they come to joint class, of course they're seen in the clinic, and that is when they usually have an interpreter. Someone, in fact, and we've operated on many patients who do not speak English, but every time they've had someone who they know in their family that does speak English. We usually have an interpreter in that situation. As far as mental illness or mental disability, the main thing I

can think of and that we ensure and that makes all the difference in the world is that family support is having multiple people there with them to help support them when they're at home.

Laura Maynard: Great. Thank you for sharing that. Those are great approaches.

Chastity King: Yes, ma'am.

Randy Thomas: This is Randy. The problem with the one size fits all, which may be somewhat of the reality is that that is about as far from patient centric care as it gets. We are all so geared towards taking the patient for who they are, finding out what their needs are ahead of time and trying to address as much as we can ahead of time within the scope that we can. I think as long as we all keep our eye really on the patient, and we are able to really find out a fair amount of them preoperatively, whether through class or through a heads up from the surgeon's office, that kind of thing, and we can address it beforehand. I think that that's really what helps the patient through everything so that it is not kind of a one size fits all approach. It still becomes a basic plan of care but then finally tuned down to what the patient's needs are.

Laura Maynard: Yeah, that's a great point Randy. I think if your program has an approach that's very patient centered to begin with, if you're looking at each individual patient and their needs and their preferences and you're used to doing it that way, you're better positioned to care for those patients that might have more complex needs or that might have unusual or different needs if you're already looking at each individual patient as an individual and what they need. Anybody else have something to add on that one, another idea or different approach?

Well, we're interested in doing a little additional follow up on that one so, we're going to ask, does your hospital have a strategy? We're going to launch a poll on this one. Do you have a strategy for effectively communicating, particularly discharge expectations? We've talked about how important it is to set that expectation with patients. If your patients have complex needs, such as these, we've been discussing, do you have a strategy for effectively communicating those discharge expectations to those patients? If you do, yes. If you don't, no, if you don't know, that's okay. So a yes, no or I don't know answer and we'll give you just a minute. Yeah, click onto that. It's looking as if, you know, by far the majority do have a strategy for that effective communication.

Give it just another moment. All right, we'll close that one out and we can show the results. As you can see, of those that responded, almost 85% do have a strategy for that. Our next poll, we will want to know for future conversations, are you willing to share your approaches to this type of communication? Are you willing to share that with your peers? So yes, no or maybe, and do note on this, that there's more than one way to share some of that sharing might be really sharing tools, sharing materials, sharing your assessments but it might be as simple as just sharing some ideas or sharing in the conversation. So all of that counts as sharing. You may or may not be able to get organizational approval to share your tools, but you still could share your approaches and ideas. Let us know if you'd be willing to share your hospital's approaches to communicating discharge expectations to patients with complex needs. Give it just another moment or two and we'll close that one out. Not necessary to broadcast those, although we can, but I will tell you that the majority of you are willing to share, which is great. That's good to hear.

Now let's think about what we're going to do with what we've heard. Basically, what are you going to do with the information that you've shared today? We want you to type into the chat pod. What are you going to do? How are you going to act? What change you're going to make? Who are you going to talk to- based on what you've heard today in this affinity group session? So be typing into the chat pod what you're going to be doing and we'll just remind you again that CMS, it's employees, agents and staff assume no responsibility for any errors or omissions in this content. CMS makes no guarantees of completeness, accuracy, or reliability for any data contained or not contained here and CMS shall not be held liable for any use of the information described and/or contained herein and assumes no responsibility for anyone's use of the information. CMS does not endorse any strategies, tactics, or vendors referred to in this webinar and the views and opinions expressed in this webinar are those of the participants and don't represent the official policy or position of CMS.

Announcements and reminders as we close out, have a Care Navigation Group on CJR Connect and that's where we can continue talking to one another today. So carry on these conversations there. Here's how to request an account on CJR Connect right there on that slide it will tell you how. Then upcoming events on July 31st our next All Participant webinar, will be using data to drive improvement, data collection, analysis and reporting. Then on August 14th, we'll be having a webinar on optimizing patient care post hospitalization. We talked a lot today about pre-hospitalization, but we're going to look at how you optimize patient care post hospitalization. If you have questions about this event send them to lscjr@lewin.com. If you have technical or programmatic questions, send those to cjrsupport@cms.hhs.gov and please do take a couple of moments to complete that post event survey that popped up. Your feedback helps us design these sessions in a way that will meet your needs. So, please take a few minutes to complete that survey. We really appreciate it and thank you, thank you, thank you all for participating today and for the great discussion. Thank you to Randy and Sheyda and Dawn and Jody, thank you for doing such great work as peer leaders for this Peer Led Care Navigation Affinity Group. Thanks everybody for your time. We will talk to you again soon.